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Improving Mental Health Care for Transgender Consumers:

Providers' Attitudes, Knowledge, and Resources

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Abstract

Transgender individuals may present for treatment with a variety of mental health needs, both related and peripheral to their gender identity and expression. Compounding stigma and other life stressors elevate mental health risks in transgender communities, and the barriers to mental health services are manifold. As such, the current research study was designed to determine the competency of mental health care providers to address the unique needs of transgender consumers. Online surveys gauged mental health providers' knowledge of transgender issues, implicit and explicit transphobic attitudes, as well as treatment decisions with transgender and cisgender consumers; moreover, workplace resources and infrastructure were assessed. Three hypotheses were tested: (1) that types of providers (i.e., different degrees and training) would vary on their implicit transphobic attitudes, explicit transphobic attitudes, and transgender-related knowledge; (2) that explicit and implicit attitudes would predict treatment of transgender consumers; and (3) that knowledge would be predictive of implicit and explicit attitudes. While implicit attitudes were not found to be significant in any of these hypotheses, explicit attitudes varied across provider types, $F(4,69) = 7.025$, $p < .01$, and were significantly correlated with knowledge $b = -.481$, $t(79) = -4.875$, $p < .001$. Knowledge also varied significantly across provider type $F(4,66) = 2.65$, $p = .041$. Finally, explicit attitudes were significantly correlated with differences in treatment decisions in working with transgender and cisgender consumers $b = .333$, $t(60) = 2.735$, $p = .008$. These results suggest that improving transgender-related competencies among mental health providers might facilitate reductions in explicit biases, thereby alleviating certain instances of discriminatory treatment toward transgender individuals in mental health care settings. Implications for advocacy and organizational change are discussed.

Keywords: transgender, mental health, implicit attitudes, health care, stigma

The compounding stressors and resulting mental health concerns faced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities are documented in a number of research studies (Meyer, 2003; Hendricks & Testa, 2012). Transgender individuals, in particular, are at the intersection of multiple stigmas, which may leave them more vulnerable to trauma, depression, substance use, and suicidality (Bockting, Knudson, & Goldberg, 2006). Nonetheless, transgender mental health is historically understudied (Lucksted, 2004). Most existing research on transgender individuals takes place in the context of the now outmoded Gender Identity Disorder (GID) diagnosis. Although researchers and clinicians are becoming increasingly aware of other concerns experienced by the transgender community, there remains a dearth of research on competencies for care provision with transgender clients.

Relatedly, not all transgender people experience Gender Dysphoria (GD; Coleman et al., 2012). Indeed, debate on the DSM-5 GD diagnosis persists, with growing speculation about the future of the diagnosis (Coleman et al., 2012). However, clinicians are apt to fixate on the GD diagnosis, rather than a more holistic picture of mental health care delivery for transgender consumers. Given this and other well-documented shortcomings in mental health care provision for transgender clients, this project looks to assess the competence, knowledge, and attitudes of mental health care providers in regards to transgender individuals.

The rapidly changing sociopolitical climate is at the crux of the LGBTQ community's advocacy efforts. Attitudes about sexual and gender minorities have changed dramatically since the mid-2000s, as evidenced by polling data and mounting legal rights (Craighill & Clement, 2014; Molloy, 2013). These transformations may have significant repercussions for LGBTQ relationships, health, and quality of life. Therefore, it is important to consider even relatively new

research—including that which is highlighted in this manuscript—within this ever-changing framework.

Transgender Identity and Research

Gender exists on a continuum, and so does biological sex; thus, categorizing sex and gender is inherently flawed. Nonetheless, this study will use the umbrella term "transgender" to refer to individuals whose assigned sex does not match their authentic gender identity along one or multiple dimensions—including gender identity, gender expression, and physical sex characteristics. Transitioning to present as one's authentic gender may or may not include hormone replacement therapy and gender confirmation surgery. However, a variety of transgender and gender nonconforming identities exist (genderqueer, gender fluid, agender, two spirit, and so forth), and self-determination of identity is ultimately the right of the individual. Moreover, some transgender individuals may prefer to be identified solely as a man or woman, rejecting the idea that transgender people must define themselves by their transition (Coleman et al., 2012). All of these intricacies of language can make research with transgender and gender nonconforming populations more complex, but it is important to recognize these nuances in identity and the unique experiences that accompany them. Research has historically failed transgender and gender nonconforming communities in this regard (Reisner et al., 2014).

Throughout the remainder of this project I will employ the term "transgender" to refer to the transgender community as a whole; I will use the term "transwomen" to specify transgender people who live and identify as women and who were assigned a male sex at birth, and I will use the term "transmen" to specify those who live and identify as men and who were assigned a female sex at birth. The term "cisgender people" will be used to refer to individuals whose assigned sex aligns with their authentic gender, and I will specify with the terms "ciswomen" and

"cismen" when appropriate. When referring to particular gender nonconforming groups within the transgender population, the appropriate terminology will be employed.

The transgender community is a vastly heterogeneous population in terms of gender identity, gender expression, biological sex, and sexual orientation. The same can be said for the cisgender population; however, the prevailing binary system of gender often essentializes men and women as opposites. We see this binary trend carry over into research on transgender individuals; much of the literature studies male-to-female (MTF) transwomen and female-to-male (FTM) transmen without much attention to the gradations in gender and sexual orientation that can be found in this population. Extremely few studies focus on the experiences of gender-queer and other gender variant individuals (Lucksted, 2004).

While much of the existing transgender literature exists within the framework of the LGBTQ community as a whole, there is increasing recognition among researchers that transgender issues often merit their own course of study. By relying on LGBTQ samples to extrapolate information on transgender participants, we are often left with small transgender samples that may vary significantly from samples that specifically recruit transgender participants. This practice of lumping together all transgender participants also risks the erasure of important within-group differences; the experiences of transwomen and transmen, for example, may differ substantially from one another as well as from gender variant individuals. Moreover, LGBTQ samples frequently overlook transgender people's sexual orientation and instead include them in a separate category (although transgender people may also identify as LGBQ), which may inadvertently result in the othering of transgender participants.

Predictors and Symptoms of Mental Illness

The prevalence of mental illness in the transgender population is not entirely known;

however, the research that does exist indicates increased rates of clinically significant symptoms

(Bockting, Knudson, & Goldberg, 2006). This increase is attributable to the disproportionate

amount of obstacles and hostility regularly faced by transgender individuals. Beyond everyday

life stressors, transgender people face discrimination, familial rejection, marginalization, and

violence due to their transgender identity (Haas et al., 2010; Richmond, 2012; Rotondi,

2012). Meyer (1995) has proposed a three-tiered model of minority stress that explains similarly

poor mental health and maladaptive coping in the LGBQ population; these three components

include (1) experiences of discrimination and oppression; (2) fear regarding potential stigma or

discriminatory events; and (3) internalized negative attitudes about one's identity. This model

has since been adapted to describe how the experiences of transgender people explain increased

risk for psychological distress (Bockting et al., 2013; Hendricks & Testa, 2012).

Transgender individuals face discrimination in multiple contexts—including sexism,

cissexism, heterosexism, and transphobia (House, Van Horn, Coppeans, & Stepleman, 2011).

Transpeople are repeatedly scrutinized on whether or not they "pass" as "real" men and women

(cissexism), and their relationships may be treated as less valid than that of heterosexual,

cisgender couples (heterosexism; Mathy, Lehmann, & Kerr, 2003). Transwomen must tackle the

additional barriers of sexism and misogyny; transpeople of color face racism and heightened

threat of violence (Richmond, Burnes, & Carroll, 2012; Singh & McKleroy, 2011; Stotzer, 2008).

Transwomen of color, moreover, face some of the highest rates of victimization among any

minority group in the United States (Singh & McKleroy, 2011). These experiences of

discrimination are intensified by elevated rates of poverty attributable to unemployment (Nemoto,

Operario, Keatley, & Villegas, 2004), as well as a general lack of social support (Garofalo,

Deleon, Osmer, Doll, & Harper, 2006; Maguen, Shipherd, & Harris, 2005; Rotondi, 2012).

Altogether, these coinciding experiences of marginalization, stigma, discrimination, and violence

can generate feelings of isolation and hopelessness—thereby intensifying the risk of poor mental

health outcomes.

Trauma

Many studies on trauma in the transgender community report rates that are more than

double that of the general United States population (Mizock & Lewis, 2008). In recent studies,

lifetime prevalence of physical victimization among transgender individuals ranged from 36% to

60%, while prevalence of sexual assault ranged from 13% to 59% (Clements-Nolle, Marx, &

Katz, 2006; Lombardi, Wilchens, Priesing, & Malouf, 2001; Testa, Sciacca, Hendricks,

Goldblum, & Bradford, 2012; Xavier, Bobbin, Singer, & Budd, 2005; Xavier, Honnold, &

Bradford, 2007). Transgender people are increasingly vulnerable to interpersonal violence due to

inadequate legal and social support. Furthermore, victimization rates are higher among ethnically

diverse transgender communities (Richmond, Burnes, & Carroll, 2012). However, no significant

differences between transmen and transwomen have been found regarding victimization

(Lombardi, Wilchens, Priesing, & Malouf, 2001; Testa, Sciacca, Hendricks, Goldblum, &

Bradford, 2012); likewise, age was not shown to predict victimization (Testa, Sciacca, Hendricks,

Goldblum, & Bradford, 2012).

Testa and colleagues (2012) examined the traumatic experiences of 179 transwomen and

92 transmen, demonstrating that of the 38% of the sample who experienced physical violence,

97.7% reported that one or more experiences of violence were attributable to their gender

identity or expression. Moreover, of the 26.6% who endorsed sexual assault, 89.2% reported that

one or more sexual assaults were due to their gender identity or expression. Among the sample, only 11.1% of physical assaults and 9.1% of sexual assaults had been reported to the police.

Likewise, intimate partner violence has been shown to be substantially higher for transgender women compared to cisgender women. A community sample of 67 transwomen found that 25% endorsed experiences of forced sex with a primary partner and 15% reported forced sex with a casual sex partner; in the same sample, 50% reported being hit by a primary partner and 22% reported being hit by a casual sex partner (Risser et al., 2005).

Shipherd, Maguen, and Skidmore (2011) studied potentially traumatic events (PTE) and post-traumatic stress disorder (PTSD) symptoms in a largely white, highly educated sample of 97 transgender individuals. The study looked at a range of PTEs, including such categories as natural disasters, stalking, and sexual assault. Ninety-eight percent of participants endorsed at least one PTE, and 91% reported multiple PTEs, with 42% reporting that one or more PTE were related to their gender identity or expression. In this sample, 17.8% of respondents met criteria for PTSD, compared to 3.5% in the general United States population (Kessler et al., 2001).

Substance Use

Overall, rates of substance use in the transgender population are elevated, as substance use is thought to be a tool for coping with compounding stressors (Mizock & Lewis, 2008). Xavier, Bobbin, Singer, & Budd (2005) surveyed 248 transpeople of color in the Washington, DC area and found that 48% reported a substance abuse problem with alcohol and/or drugs across the lifetime. Another study of racially diverse young transwomen found that 60% had reported using substances and/or alcohol in the past 3 months (Hotton, Garofalo, Kuhns, & Johnson, 2013). In a study of 179 transwomen and 92 transmen, 74.3% of transwomen reported ever using illicit drugs, compared to 77.2% of transmen.

Suicide

Numerous studies have demonstrated lamentably high prevalence of suicidal thoughts and attempts across the lifespan for transgender individuals. Most research has shown that at least one-half of transgender individuals have thought about suicide at some point over the course of their lives (Kenagy, 2005; Kenagy & Bostwick, 2005; Risser et al., 2005), though exact estimates of suicidal ideation have ranged from 38% (Xavier, Bobbin, Singer, & Budd, 2005) to 65% (Xavier, Honnold, & Bradford, 2007). In an online survey inquiring about suicidal ideation in the past two weeks, 25% of respondents in Australia and New Zealand endorsed suicidal thoughts, with transmen reporting significantly higher ideation than transwomen (28.3% versus 14.8%, respectively; Pitts, Couch, Mulcare, Croy, & Mitchell, 2009).

Rates of suicide attempts were similarly high, reported by around one-third of respondents across studies (Clements-Nolle, Marx, & Katz, 2006; Goldblum, Testa, Hendricks, Bradford, & Bongar, 2012; Kenagy, 2005; Kenagy & Bostwick, 2005; Risser et al., 2005), although reported attempts ranged from 16% (Xavier, Bobbin, Singer, & Budd, 2005) to 41% (Xavier, Honnold, & Bradford, 2007). This is vastly higher than the general U.S. population, in which the rate of lifetime suicide attempts approaches 2.7% (Kessler et al., 2001). For both suicidal ideation and attempts, the lowest rates were found in a population of 248 transpeople of color in the Washington, DC area; this is in line with previous research showing racial and ethnic minority status to be a protective factor against suicide (Xavier, Bobbin, Singer, & Budd, 2005).

Several studies have reported on transgender-related stressors that may have prompted individuals to think about or attempt suicide. Of participants who endorsed suicidal ideation, 31% of a Philadelphia area sample (Kenagy, 2005) and 60% of a Chicago area sample (Kenagy & Bostwick, 2005) attributed these thoughts to transgender-related stressors. Suicide attempts

were attributed to transgender-related stressors among 13% of respondents endorsing a suicide

attempt in the Philadelphia area sample and among 52% in the Chicago area sample. Xavier,

Honnold, & Bradford (2007) found a gender difference in regards to suicidal ideation in response

to transgender-related stressors; of participants who endorsed any suicidal ideation, 62% of

transwomen attributed the thoughts to transgender-related stressors as opposed to 39% of

transmen.

In a sample of 329 transwomen and 123 transmen, suicide attempts (endorsed by 32% of

the sample) were associated with younger age, depression, history of substance use treatment,

history of forced sex, gender-based discrimination, and gender-based victimization (Clements-

Nolle, Marx, & Katz, 2006); similar association between histories of sexual and/or physical

violence and suicide attempts were found by Testa and colleagues (2012). Goldblum, Testa,

Hendricks, Bradford, & Bongar (2012) found that experiences of school gender-based violence

were predictive of lifetime suicide attempts; specifically, individuals reporting gender-based

violence during their education were four times more likely to have attempted suicide than those

without such experiences. These associations between suicide and mounting stressors—many of

which are related to minority status—reflect the suppositions outlined by the minority stress

model, making it a useful tool to use in studies focused on transgender populations.

Depression

Reports of clinically significant symptoms of depression in the transgender population

range from one-half to around two-thirds (Bockting, Huang, Ding, Robinson, & Rosser, 2005;

Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Budge, Adelson, & Howard,

2013; Clements-Nolle, Marx, Guzman, & Katz, 2001; Clements-Nolle, Marx, & Katz 2005;

Shipherd, Maguen, Skidmore, & Abramovitz, 2011). In contrast, twelve-month prevalence of

major depressive disorder in the United States is approximately 7% (American Psychiatric

Association, 2013). Transwomen tended to score significantly lower on measures of depression

than transmen (Clements-Nolle, Marx, & Katz, 1999; Gonzales, 2008; Pitts, Couch, Mulcare,

Croy, & Mitchell, 2009; Shipherd, Maguen, Skidmore, & Abramovitz, 2011); however, one

recent study found transwomen to score significantly higher than transmen on depression items

from the short-form of the Brief Symptom Inventory (Bockting, Miner, Swinburne Romine,

Hamilton, & Coleman, 2013).

Risk factors for depression in the transgender community include heightened incidence of

stigma, discrimination, and abuse (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman,

2013; Rotondi, 2012). A study by Sugano, Nemoto, & Operario (2006) found that depressed

transgender individuals were more likely to have experienced transphobic events. Time spent

presenting as one's authentic gender has also been linked to increased lifetime prevalence of

depressive symptoms, likely due to a lengthened timespan during which oppression and

victimization can occur (Shipherd, Maguen, Skidmore, & Abramovitz, 2011). Finally, depressive

symptoms may be exacerbated by hormone replacement therapy (Slabbekoorn, van Goozen,

Gooren, & Cohen-Kettenis, 2001; Wassersug et al., 2007), low socioeconomic status (Dean et al.,

2000; Rotondi, 2012), and low social support (Budge, Adelson, & Howard, 2013; Garofalo,

Deleon, Osmer, Doll, & Harper, 2006).

Anxiety

Despite the high prevalence of anxiety in the general population, little research has been

done on the prevalence of anxiety in the transgender community. The minority stress model

posits that the threat of discriminatory events constantly weigh on the minds of stigmatized

groups, thus heightening arousal and anxiety symptoms. Clinically significant symptoms of

anxiety were reported by 33.2% of transgender participants in an online survey (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). While Bockting and colleagues showed that clinically significant anxiety symptoms were relatively equal for transwomen and transmen, Budge, Adelson, & Howard (2013) found contradicting results, with an increase of symptoms in transmen, such that 40.4% of transwomen experienced high levels of anxiety as compared to 47.5% of transmen. Anxiety symptoms in both of these studies were positively associated with experiences of stigma and avoidant coping.

Other Disorders

Few studies explore other symptoms of mental illness in the transgender community. Rates of somatization appear to be marginally elevated among transgender individuals; an online survey of transgender individuals found the lifetime prevalence of somatization to be around 27.5% (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). A study by de Vries, Noens, Cohen-Kettenis, Berckelaer-Onnes, & Doreleijers (2010) found that in a sample of 204 children receiving care at a gender identity clinic, 7.8% met criteria for autism spectrum disorder, as opposed to around 1% in the general population (American Psychiatric Association, 2013). Although several studies explore the unique manifestations of eating disorders (Ålgars, Alanko, Santtila, & Sandnabba, 2012; Khoosal, Langham, Palmer, Terry, & Minajagi, 2009), dissociation (Kersting et al., 2003), and schizophrenia (Garrett, 2004; Mizock & Fleming, 2011) among transgender individuals, little is known about their prevalence.

Summary

While there is an overall paucity of research on mental illness in the transgender community, researchers and clinicians alike are becoming gradually more aware of the mental health needs of this population. Beyond the physical and social challenges associated with

gender transition, transgender individuals must face ongoing threats of violence and

discrimination due to their gender identity and expression. The stigma surrounding transgender

identity furthermore contributes to inflated rates of homelessness, unemployment, and

relationship strain (Hendricks & Testa, 2012). These difficulties, in turn, may impede access to

health care services. Ultimately, these mounting stressors may contribute to increased

psychological distress in addition to the exacerbation of any existing mental illness.

Nevertheless, certain protective factors may help relieve or prevent mental health

concerns among transgender people. Demographic factors such as older age, more education,

and increased income are associated with better mental health outcomes. Moreover, transgender

community size, family support, and identity pride have been negatively associated with

psychological distress (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). In

an online survey of 253 transgender individuals, 65% reported feeling extremely happy with

their lives, with most reporting an increase in psychological well-being after transition (Pitts,

Couch, Mulcare, Croy, & Mitchell, 2009). Likewise, Newfield, Heart, Dibble, & Kohler (2006)

found a general increase in transmen's quality of life once they began receiving hormone

replacement therapy. These findings suggest that both transition and identity affirmation may

play pivotal roles in warding off poor mental health outcomes among transgender individuals.

Hopefully, the aforementioned mental health disparities will diminish as sociopolitical support

for the transgender community continues to build.

Accessing Mental Health Care

Transgender individuals face multiple sources of stigma as they navigate the mental

health care system. Just as transgender people face a persistent threat of discrimination in their

daily lives, the potential for hostility persists when accessing health services. Moreover, the

threat of discrimination is amplified in the health care setting due to the potential barriers to accessing necessary mental and physical health services (Coleman et al., 2012).

In addition to transphobia, transgender mental health consumers face the stigma associated with mental illness and receipt of therapy; they may be wary of fueling accusations that equate transgender identity with mental illness (Mizock & Fleming, 2011). Furthermore, transgender mental health consumers encounter unique barriers to care that may impede on meaningful service utilization and recovery.

Transgender Individuals and Mental Health Treatment

Historically, mental health providers have served as gatekeepers to the transition process, whereby their approval was needed to access hormone replacement therapy and gender confirmation surgery (Coleman et al., 2012). This model of care persists in today and can have a tremendous impact on the treatment process. Mental health providers have traditionally determined a transgender individual's readiness for transition; as such, any counter- indication could delay an individual's transition or prevent it altogether. Often, transgender consumers would present with an archetypal transgender narrative, well-versed in the DSM criteria for GID (Coleman et al., 2012); these narratives might include hyper-masculine or hyper-feminine traits, interest in their authentic gender's stereotypical activities and dress ever since childhood, as well as longstanding disgust with their anatomy. Not only would this narrative performance prevent a meaningful therapeutic relationship, but it would also preclude the assessment of psychological distress that trends higher in the transgender population due to minority stress.

Regardless of whether a transgender individual experiences gender dysphoria, clinicians practicing affirmative therapy techniques should still assess for points of resiliency and additional psychological distress if their services are sought by transgender consumers. Given the

stressors associated with being transgender, a thorough psychosocial evaluation can help assess

for useful interventions and resources. The DSM-5 refers to gender dysphoria as "clinically

significant distress or impairment in social, occupational or other important areas of functioning"

that occurs due to transgender identity (American Psychiatric Association, 2013); whereas

transgender people may experience distress due to stigma and discrimination, they might not be

concerned about the misalignment of their assigned sex and gender identity. Thus, a diagnosis of

GD might not be appropriate for all transgender consumers. Nevertheless, the pressure to

represent the prototypical transgender experience may persist, even when receiving care from an

informed and affirmative provider. Transgender consumers may continue to fear that admitting

to psychological distress or mental illness symptoms would disqualify them from transition

procedures, just as it had in the past (Coleman et al., 2012; Neumann Mascis, 2011).

Conversely, the GD diagnosis at times precludes the assessment and treatment of other

forms of psychological distress. Should a transgender individual present for treatment, the mental

health provider might hyper-focus on the transgender experience, attribute any and all

psychological distress to GD, and thus fail to assess for and meaningfully treat existing

psychopathology (Benson, 2013). The mental health needs of transgender individuals are similar

to the cisgender population in many ways, and these needs may or may not be related to stressors

associated with their gender identity and expression (Bockting, Knudson, & Goldberg, 2006;

Shipherd, Green, & Abramovitz, 2010).

Current Utilization of Mental Health Services by Transgender Individuals

As with the cisgender population, fewer transgender individuals access mental health care

than meet the criteria for psychological distress. In a study of 130 transgender participants,

Shipherd, Green, & Abramovitz (2010) found that 52% of respondents met criteria for

psychological distress but did not seek mental health services in the past year, whereas 37% had

accessed treatment for mental health concerns other than GD. An earlier survey of 179

transgender individuals in British Columbia found that 39% reported a current need for mental

health services not relating to GD (Goldberg, Matte, MacMillan, & Hudspith, 2003). A survey of

Australian and New Zealander transgender people found that 47.4% had a current counselor,

psychologist, or psychiatrist for both GD-related and non-GD-related mental health concerns

(Pitts, Couch, Mulcare, Croy, & Mitchell, 2009).

In addition to current mental health care need and utilization, Shipherd and colleagues

studied the types of mental health services accessed by transgender consumers; 20% reported

seeking mental health care services for depression or excessive sadness, 19% for anxiety or

worry, 18.5% for relationship issues, 9% for PTSD, 8.5% for sleep problems, 6% for grief, 3%

for eating and weight disturbances, and 1.5% for drug abuse or alcoholism.

Barriers to Care

The most frequently endorsed barriers to mental health care among transgender

individuals have been reported as cost, previous bad experiences, fear of discrimination, and

stigma (Shipherd, Green, & Abramovitz, 2010). Whereas cost and previous bad experiences have

also been reported by the cisgender population as barriers to mental health care, the latter

concerns are specific to marginalized groups (Kessler et al., 2001). Cost may be a particularly

insurmountable barrier for transgender individuals with fewer financial resources, which is more

common among younger transgender people as well as transgender people of color (Benson,

2013; Nemoto, Operario, & Keatley, 2008; Pitts, Couch, Mulcare, Croy, & Mitchell, 2009).

Moreover, geographic location may play a large role in access to affirmative providers,

particularly in rural settings and areas without non-discrimination ordinances; urban areas

generally provide a larger selection of providers and more support and advocacy organizations for the transgender community.

Discrimination in the health care setting. Unfortunately, fear of maltreatment in the health care setting is not unfounded. A needs assessment survey of 81 transgender people in the Philadelphia area found that a notable proportion of the transgender sample had been refused mental health care; 7% had been refused counseling altogether, and 10% had been refused counseling for trans-related issues (Kenagy, 2005). Similarly, a survey of New York City area transgender individuals found that 40% failed to seek substance use treatment because of fear of discrimination. Semi-structured interviews with 85 transgender participants in Ontario revealed a common theme of active discrimination and stigma in the health care setting; this included events in which providers exhibited visible discomfort with their transgender consumers, outright refusal of services, as well as aggression and intimidation (Bauer et al., 2009). The fear of discrimination may result in treatment interfering behaviors, such as the concealment of transgender identity or persistent hypervigilance as a means to protect oneself from discrimination and hostility (Kidd, Vletman, Gately, Chan, & Cohen, 2011; Lucksted, 2004).

Provider knowledge. One of the most commonly cited barriers to adequate care is lack of provider knowledge about transgender issues (Bauer et al., 2009; Goldberg, 2006; Lucksted, 2004; Pitts, Couch, Mulcare, Croy, & Mitchell, 2009; Rutherford, McIntyre, Daley, & Ross, 2012). Transgender consumers often find themselves in the position of educating their providers about transgender experiences and their health care needs (Benson, 2013; Kidd, Veltman, Gately, Chan, & Cohen, 2011). Indeed, Rachlin, Green, & Lombardi (2008) found that only 5% of counselors in several substance abuse treatment programs received any formal education about transgender individuals; likewise, Elison & Hughes (2004) found that about 50% of mental

health providers lacked a basic knowledge of transgender issues. In particular, more

sophisticated education about hormone replacement therapy and the transition process would

benefit providers (Nemoto, Operario, & Keatley, 2008).

Infrastructure. Many mental health facilities have yet to establish a culturally sensitive

infrastructure for transgender consumers. Residential facilities are often segregated by biological

or perceived sex, which may undermine the authentic gender of transgender consumers. Sex-

segregated restrooms may also be a concern for some transgender consumers; all-gender

restrooms should be available to provide a safe and comfortable space for people with any

gender identity or expression (Nemoto, Operarior, & Keatley, 2008). Finally, standardized forms

and medical records should adequately and sensitively capture both gender identity and assigned

sex to avoid erasure and othering of transgender identities (Rutherford, McIntyre, Daley, & Ross,

2012).

Cultural considerations. Finally, not all transgender people experience barriers to

mental health care equally. Nemoto, Operario, & Keatley (2008) conducted 48 focus groups and

collected 332 surveys from a culturally diverse sample of transgender individuals in the San

Francisco area. In terms of perceived barriers to care, Latina/o respondents reported the most,

followed by Asian and Pacific Islander respondents; African American respondents reported the

fewest perceived barriers. Thus, barriers to care may vary depending on mounting stigmas,

financial resources, as well as community values and support.

Summary

Besides the barriers to mental health care faced by the cisgender population, transgender

consumers must overcome additional barriers of stigma, discrimination, and providers' lack of

knowledge. More education is needed for mental health providers and staff in order to create an

inclusive and welcoming therapeutic environment (Bockting, Kundson, & Goldberg, 2006; Rutherford, McIntyre, Daley, & Ross, 2012); even small gestures of cultural sensitivity and knowledge of transgender issues can help to establish a more inclusive treatment milieu. Affirmative therapy techniques that validate transgender consumers are essential for establishing a meaningful and open therapeutic relationship (Benson, 2013; Bockting, Knudson, & Goldberg, 2006; Coleman et al., 2012).

Despite the unique concerns and barriers to care experienced by transgender individuals, they present in treatment with many of the same issues experienced by cisgender consumers (Shipherd, Green, & Abramovitz, 2010). Although providers should be sensitive to the stressors that are specific to transgender consumers, a focus on GD should not preclude the assessment and treatment of other mental health concerns. Resolving psychological distress will likely ease any GD-related distress, and vice versa (Coleman et al., 2012).

Implicit and Explicit Attitudes

Explicit biases are observable manifestations of known attitudes. Individuals harboring explicit biases are able to either identify their attitudes or confirm behaviors that align with these attitudes. For example, an individual may or may not identify as disliking transgender people, but the same individual may confirm a biased item on the Genderism and Transphobia scale such as, "Sex change operations are morally wrong" (GTS; Hill & Willoughby, 2005).

Conversely, implicit attitudes can be thought of as relatively automatic and difficult to consciously manipulate; they occur even without awareness or sufficient cognitive resources such as time and attention (Spruyt & Moors, 2009). Whereas an individual responding to a measure of explicit attitudes such as the GTS could choose to change their responses to seem more tolerant, participants involved in a measure of implicit bias would have difficulty masking

their subconscious attitudes. Implicit measures generally compute reaction times to gauge the automaticity of responding; relatively immediate responses usually point to implicit attitudes, and prolonged responding may indicate a conscious struggle against potential implicit biases. Moreover, mistakes when responding to these measures may indicate implicit attitudes as well.

Research suggests that providers' implicitly harbored biases toward select groups of patients can affect health care delivery (Green et al., 2007; Sabin, Rivara, & Greenwald). These biases are stronger when the provider does not share that minority identity, as has been demonstrated with sexual orientation (Cochran, Peavy, & Cauce, 2008) and race (Sabin, Rivera, & Greenwald, 2008). Implicit biases may have potentially harmful implications for treatment, even in the absence of explicit prejudice (Green et al., 2007). As cultural forces become less tolerant of overt homophobia and transphobia, the question of how implicit bias manifests itself becomes more salient. Currently, no studies have examined implicit transphobia.

The Current Study

Despite the recently expanding body of literature assessing mental illness among transgender individuals, more research is warranted to adequately assess and treat the mental health needs of this population. There is little knowledge of the transgender consumers' first-hand experiences in the mental health care system, and only few, dated studies assess the ability of mental health providers to care for transgender individuals. Furthermore, research must keep pace with sociopolitical shifts that have immediate consequences for the transgender community. The stressors faced by transgender people, as well as providers' knowledge and attitudes about their transgender consumers, must be consistently reevaluated in light of cultural and political gains.

In addition to elevated risk for victimization and resulting psychological distress, transgender people are frequently referred to mental health care during physical gender transition; thus, the mental health care system should be well equipped to care for transgender consumers who may or may not be seeking care of their own accord. Nonetheless, accessing a well-informed, affirmative mental health provider remains an uncertain process outside of specialty gender clinics. Provider ignorance and bias has the potential to put undue burdens on transgender individuals to educate their providers, or could even prove psychologically harmful to the consumer. In response, the World Professional Association for Transgender Health (WPATH) has put together standards of care for transgender consumers that emphasize affirmative practice (Coleman et al., 2012); however, providers' knowledge and utilization of the standards of care remain unknown.

The current study employs exploratory analyses to describe mental health care providers' ability to care for transgender consumers by examining (1) their training experiences and knowledge of gender minorities, (2) implicit and explicit transphobia, (3) resources and transgender-sensitive infrastructure available within their workplace, as well as (4) treatment decisions regarding transgender and cisgender consumers. Results will be used to determine gaps in provider knowledge and potential areas for improvement at the system level.

Additionally, three hypotheses are presented: (1) knowledge and attitudes regarding gender minorities will vary across clinical psychologists, counseling psychologists, psychiatrists, and social workers; (2) implicit and explicit transphobic attitudes will predict providers' reactions to vignettes with transgender and cisgender consumers; and (3) better knowledge of transgender issues will be negatively related to both implicit and explicit transphobic attitudes.

Method

Participants

Participants in this study ($N = 107$) include licensed, pre-licensure, and in-training mental health providers across multiple disciplines: clinical psychology, counseling, social work, psychiatry, and related mental health professions (e.g., LAC, residential treatment assistant, etc.). Mental health providers were recruited from a variety of settings, including community mental health centers, outpatient mental health clinics, inpatient psychiatric units, residential treatment facilities, and private practices (Table 1).

Recruitment emails were sent to a total of 158 listservs and 360 academic and health care settings across the United States. Due to the sensitivity of implicit measures to priming effects, emails did not mention the specific nature of the study. Likely due to the vagueness of the recruitment message, as well as the length of the survey (approximately 40 minutes), fewer participants completed the survey than the anticipated sample size of 150 participants; this goal sample size had been determined by power analyses with power of .8 and effect size of .2 for both a correlation and for an ANCOVA with 4 groups and 1 degree of freedom in the numerator (relevant to hypotheses one and three, respectively). One hundred twenty-four people opened the link to the survey, 107 participants began completing the survey questions but did not finish, and 78 participants completed the survey.

Measures

Demographic and background data (Appendix A). Demographic information was collected regarding providers' age, gender, sexual orientation, ethnicity, and location. Professional backgrounds were also recorded, including provider type, education, years in practice/training, and work setting. Finally, personal interactions with LGBTQ individuals were assessed; participants were asked how many gender or sexual minority acquaintances, friends,

family members, colleagues, and consumers they have had throughout their lives (demographic and background data are reported in Table 1).

Knowledge of gender minorities (Appendix B)**.** Participants reported on their training and knowledge concerning transgender issues (Table 2). Knowledge was measured according to participants' self-report on a five-point scale (where 1 = strongly agree, and 5 = strongly disagree), as well as their replies to open-ended questions. Knowledge questions covered areas such as appropriate terminology and pronoun use, dimensions of gender, options for gender transition, and population-specific health risks. Moreover, participants were asked about their general knowledge and confidence in working with transgender consumers on a five-point scale, ranging from 1 = extremely confident to 5 = not confident at all. Knowledge scores are the calculated averages of these close-ended items.

Explicit transphobic attitudes (Appendix C)**.** Explicit attitudes regarding transgender individuals were measured using the GTS (Table 2; Hill & Willoughby, 2005). The GTS is a 32-item questionnaire that measures attitudes regarding transgender people along three primary domains: (1) transphobia, or disdain for and aversion of transgender individuals; (2) genderism, or the negative evaluation of gender non-conformity; and (3) gender-bashing, or the victimization and harassment of gender non-conforming individuals. Responses are measured on a seven-point scale, where 1 = strongly agree and 7 = strongly disagree. Responses closer to 1 represent more transphobic attitudes on all but 5 items; these five items were reverse scored to produce a meaningful average score of explicit transphobic bias. For the GTS, Hill and Willoughby demonstrated good internal consistency estimates, where coefficient α = .95.

Implicit transphobic attitudes (Appendix D). Because no implicit measure of transphobic attitudes exists, a measure was crafted to capture transphobic and cissexist attitudes

at the implicit level (Table 2). The generally accepted criteria for implicit measures to be

considered are that (1) the psychological component being studied is causally linked to the

measurement outcomes, and (2) responding to the measure is, at some level, automatic (De

Houwer & Teige-Mocigemba, 2009).

Thus, the constructed measure records the automaticity of affective responses following

transgender- and cisgender-related stimuli in order to capture the implicit valence assigned to

each set of stimuli. This has been achieved through an affective priming task (Fazio, 2001), in

which spreading activation of a semantic network primes someone to respond to similar stimuli

(Collins & Loftus, 1975). In affective priming, participants are exposed to a prime, and then a

target image or word is displayed. With an emphasis on time, participants are asked to rate the

degree to which the target is positive or negative. In a task where the prime and target are

congruent on emotional valence (for example, sunshine/smile), the participant should take less

time responding to the target. When the prime and target are incongruent on emotional valence

(for example, sunshine/illness), it should take the participant more time to respond to the target.

Reaction time should therefore be related to the proximity of the prime and target in the

respondent's semantic network, and mistakes may indicate an implicit bias. Similar affective

priming tasks have shown in-group bias in regards to race (Weisbuch & Ambady, 2008).

This study uses transgender-related, cisgender-related, and neutral images as primes and

pairs them with positive or negative targets. Participants were asked to respond to how positive

or negative the target was on a 3-point scale, where 1 = negative, 2 = neutral, and 3 = positive.

Transgender-related stimuli include photos of transgender individuals before and after they

present as their authentic gender (according to societal standards). Cisgender related stimuli

include photos of cisgender adults in two different outfits and poses. Thirteen neutral trials

occurred before the actual measure; 3 of these trials were used to acquaint the user with measure, and the last ten aided in establishing a mean baseline responding time. Neutral stimuli included images of everyday objects, such as a chair or mug.

Scoring this implicit task takes into consideration both response times and correct responding to targeted images. In particular, response times linked to incorrect responses were removed in the final implicit score, in line with previous research on calculating implicit tasks (e.g., Weisbuch & Ambady, 2008). Prior to this removal, however, a t-test was used to determine if there were significant differences in correct responding in the two conditions, as more mistakes in the transgender-related stimuli condition would suggest greater implicit bias. In addition, response times that took longer than three standard deviations from the mean were eliminated, as this prolonged reaction interval suggests that participants were distracted mid-task. Finally, mean response times were calculated for the remaining four conditions: cisgender x positive, cisgender x negative, transgender x positive, and transgender x negative. The differences between these means were used to represent the final implicit bias score.

Workplace checklist for transgender resources and infrastructure (Appendix E)**.** Participants responded to a checklist of workplace resources and infrastructure, wherein they reported if relevant resources and infrastructure are present or not at their workplaces, or if they were uncertain of these features (Table 2). Descriptive statistics combined responses of "no" and "uncertain," as uncertainty about the availability of transgender-related resources can effectively make them unobtainable to clients.

Differential reactions to transgender and cisgender consumers (Appendix F)**.** Six vignettes—three vignettes involving transgender consumers, and three comparable vignettes involving cisgender consumers—were presented in random order to gauge participants'

differential reactions. Each involved the actions of a colleague working with either a transgender or cisgender consumer; participants were asked to rate how much they agree or disagree with the colleague's actions. Responses were measured with a seven-point scale where 1 = strongly agree and 7 = strongly disagree, along with an open-ended response to explain their level of agreement. Total response scores on these vignettes were calculated by finding the mean difference between comparable vignettes; larger differences represent a greater difference in responding to transgender and cisgender conditions.

Procedure

The survey was made available online through the Qualtrics survey system, and links were sent via e-mail through various professional listservs. To avoid priming effects, the specific nature of the study was not disclosed (i.e., studying transgender-related attitudes and knowledge), and instead participation was requested for a study on mental health providers' knowledge and training. Due to the anonymous nature of online surveys, participants first provided their assent to be involved in this research, and then had the option to be entered into a raffle to win a $50 gift card at the end of the survey. To avoid unwanted priming effects, measures in the survey were ordered intentionally: vignette #1, affective priming task, vignette #2, knowledge of transgender issues, vignette #3, the GTS, vignette #4, the workplace checklist, vignette #5, demographic data, and lastly, vignette #6. All measures and procedures were approved by the University of Montana Institutional Review Board.

Results

Descriptive statistics were run on providers' demographic information (Table 1), knowledge of transgender issues, and workplace resources in order to underscore strengths and weaknesses at the provider and system levels. Descriptive statistics also describe means and

standard deviations of providers' explicit and implicit attitudes regarding transgender individuals

(Table 2).

Differences in knowledge and attitudes by provider type

To answer the first hypothesis, fixed-effects ANCOVAs were run to determine if there

were significant differences in explicit attitudes ($n = 88$), implicit attitudes ($n = 56$), and

knowledge ($n = 91$) across provider subtype, while covarying for age. These analyses revealed a

significant difference between provider types regarding explicit transphobic attitudes, $F(4,69) =$

7.025, partial eta squared = .138, $p < .01$, and knowledge, $F(4,66) = 2.65$, partial eta squared

=.289, $p = .041$. However, no differences between provider types were found concerning implicit

transphobic attitudes, $F(4,45) = .388$, partial eta squared = .033, $p = .816$. Post-hoc analyses

revealed that psychiatrists were significantly less likely to demonstrate explicit positive

transgender attitudes ($p < .05$), whereas social workers were significantly more likely to

demonstrate more comprehensive transgender-related knowledge ($p < .05$); other differences

between provider types across these variables were insignificant. Provider differences on these

and other key variables are outlined in Table 3.

Treatment decisions and providers' biases

Correlations were conducted to evaluate the second hypothesis. A simple correlation

demonstrated the way in which providers' explicit transphobic attitudes, as measured by the GTS,

was significantly correlated with their treatment decisions concerning transgender and cisgender

consumers as proposed by the six vignettes ($n = 79$), $b = .333$, $t(60) = 2.735$, $p = .008$.

To determine the relative impact of implicit attitudes on treatment decisions, a t-test first

revealed that there was a significant difference between transgender-related and cisgender-

related stimuli, $t(57) = 30.03$, $p < .001$, wherein individuals were *more* likely to answer correctly

to transgender-related stimuli (M = 14.690, SD = 3.652) than cisgender-related stimuli (M = 12.655, SD = 3.209). This suggests that negative transphobic attitudes were either not captured in this measure or were absent in participants' responding. A semipartial correlation was used to determine the relative contribution of implicit attitudes, above and beyond explicit transphobia, as they relate to the hypothetical treatment decisions described in the vignettes. However, implicit transphobia was not shown to correlate with treatment decisions in this model, b = .188, $t(60)$ = 1.242, p = .221.

Knowledge and providers' biases

The third hypothesis was analyzed through simple linear regression. In this model, explicit transphobic attitudes were associated with less transgender-related knowledge, b = -.481, $t(79)$ = -4.875, $p < .001$. However, a second simple linear regression revealed that providers' scores on the implicit measure of transphobic attitudes were not correlated with related knowledge, b = .060, $t(51)$ = .433, p = .667.

Several themes were identified in providers' responses to open-ended knowledge questions that queried providers to provide definitions for the terms "transgender," "cisgender," "genderqueer," "transman," and "transwoman." Thematic analysis was used to ascertain common elements of these definitions. In particular, 83 definitions (18.4%) were *incorrect* (e.g., "I think [genderqueer] is another term for homosexuality."), 72 definitions (16%) evidenced outright *uncertainty* about the terms (e.g., "Huh?"), and 71 definitions were appropriately *validating and accurate* (e.g., "Genderqueer can mean different things depending on the person, but generally means that a person may not identify within the bounds of conventional gender distinctions."). Most common, however, were definitions that were *microaggressing*, wherein responses were generally approaching an understanding of the concepts but were invalidating of

gender minority experiences (e.g., "[A transman is] someone who has become a man."). Relative

to providers' overall confidence in their transgender-related knowledge (

Discussion

Potential Implications

Transgender mental health consumers face disproportionate mental health risks and

barriers to care, largely due to compounding stigmas. This study aimed to assess the state of

training and competence of mental health providers to care for transgender consumers. Results

from this study suggest that explicit transphobia persists among mental health care providers, and

that these attitudes may be linked to providers' knowledge bases and treatment decisions when

working with transgender individuals. Moreover, providers' capacities for caring for transgender

clients may vary based on their fields, suggesting systemic gaps in training competencies.

Data on providers' knowledge, workplace resources, and transphobic attitudes suggest

that more systemic changes are warranted for addressing gaps in care delivery for transgender

individuals. While it is clear that training *is* underway and that resources are being allocated

toward issues of gender identity, the data gleaned in this study demonstrate that providers'

knowledge and resources regarding their transgender clients are frequently limited. However, the

results of this study suggest that certain fields need more competency training than others, and

resources should be allocated accordingly. Future efforts should continue adding to care

providers' knowledge of transgender-related terminology, referral resources, transition

procedures, and standards of care in the hopes of standardizing competencies across fields and

health care settings. Moreover, the differences found between provider types suggests that

strengths may exist in particular training models, and that these models might be adaptable

across a variety of training programs.

Furthermore, variables related to transgender-specific knowledge in this study were

significantly associated with providers' explicit transphobic attitudes, which in turn were linked

with treatment decisions for working with transgender individuals that were distinct from how

providers might interact with a cisgender individual in similar circumstances. Thus, enhancing

system- and provider- level competencies for transgender care provision could potentially

alleviate some of the discrimination faced by transgender consumers accessing care. The

association of explicit transphobic bias with treatment decisions also raises important ethical

concerns regarding the nature of provider competencies.

Nonetheless, the implicit measure of transphobic bias in this study was not significantly

associated with other tested variables. This contradicts previous research demonstrating the

relationship between implicit racist biases on treatment decisions in the medical field, above and

beyond the effect of explicit racial biases (Green et al., 2007). Because this study employed a

novel measure, wherein an affective priming task with original stimuli was completed remotely,

it seems more likely that the error lies in this specific measure of implicit bias, not the theory.

This could be due to several possible variables, including the complexity of the target stimuli

(research suggests that target stimuli should be fairly simple in their dimensions; e.g., De

Houwer & Teige-Mocigemba, 2009), or the lack of standardization in administering an

experimental task remotely. However, the accessibility and flexible application of the affective

priming task would make it a promising measure of implicit bias for researchers, and future

study should focus on testing new target stimuli with fewer dimensions of complexity.

New research is addressing the feasibility of both continuing education and training

resources for improving providers' competence in working with transgender and gender

nonconforming clients (e.g., Compton & Whitehead, 2015). These studies suggest that previous

learning of transgender-related issues is often limited for providers, and that these educational

experiences have typically taken place outside of trainings, workshops, and programs of study

for mental health care workers. Future studies should explore accredited training programs'

current transgender-related content in order to best identify points of intervention and

enhancement for future implementation transgender-focused educational content.

Limitations

This study has several limitations. First, self-report bias may have resulted in more

socially desirable responses to questions about transgender-related knowledge and explicit

attitudes. Furthermore, because data were collected remotely, participation in the affective

priming task of implicit bias was not carefully controlled, possibly resulting in distractions,

computer errors, and extraneous variables that may have skewed responding. This was the first

use of an affective priming task assessing for implicit transphobic bias, and future research

should apply the lessons learned in this study to improve on the utility of affective priming tasks

for measuring implicit bias.

This study is also limited by its power. Likely due to the length of the study, as well as

user-end computer errors on the implicit task, a diminished proportion of participants completed

the measure. Under-powered analyses are subject to the potential of Type II errors, in which real

results do not reach predetermined levels of significance. Future research would benefit from

relying on brief measures and providing specific aims for mental health providers' participation

in order to obtain larger samples.

Additionally, this study frequently lumps together all transgender identities, rather than

extensively studying reactions to different transgender and gender nonconforming identities.

This is problematic in the sense that bias regarding transmen, transwomen, and gender

nonconforming individuals may occur at different intensities and may manifest in varying ways. Moreover, this project does not consider how providers view transgender people of varying race, religion, ability, and other intersecting identities that might have a large effect on compounding bias. More research on attitudes regarding specific groups of transgender people is warranted to fully understand layers of transphobic bias.

Finally, this research focuses primarily on adult transgender populations. There are additional considerations regarding the health of transgender youth, and it is likely that they have different experiences with psychological stressors and the health care system than transgender adults. Mental health providers' views, treatment, and understanding of transgender people may vary across youth and adulthood, with important implications for treatment.

Future Research

This study aims to identify shortcomings and suggest areas of improvement for service accessibility and gender minorities' care delivery in the mental health field. These findings highlight possible routes for the most effective content and goals of these trainings, but more research is needed to determine feasible implementation processes. While LGBTQ trainings and courses exist for current and aspiring mental health providers, more specific education is needed in regards to gender minority consumers.

Mental health providers often lack basic information regarding transgender individuals (Eliason & Hughes, 2004); results here suggest that this is especially true in regards to gender transition and how to best support consumers and their families during the process. In order to provide optimal services for transgender individuals, mental health providers need better knowledge of the options, physical effects, psychological effects, risks, and benefits associated with physical transitioning. Future research should explore the effectiveness of transgender-

specific training among mental health providers, as well as ways to implement this training systemically.

As it becomes less socially acceptable to express sexist, cissexist, transphobic, and other prejudicial sentiments in the changing sociopolitical U.S. landscape, it becomes all the more important to focus research on the more subtle manifestations of stigma and bias. While this study failed to find significant results in relation to its measure of implicit transphobic attitudes, the lessons learned herein could provide a promising jumping off point for future, widespread measurement of subtle transphobia. More research on these implicit biases is warranted in the field of LGBTQ research as a whole in order to call attention to more nuanced microaggressions and discriminatory behaviors.

Conclusion

Transgender individuals experience higher risk of psychological distress, yet repeatedly cite a multitude of barriers to adequate mental health care. While most of the existing research looks at the self-reported experiences of invalidation and discrimination faced by transgender mental health consumers, few studies look at the provider- and system-end reports of care barriers. Thus, this study sought to place the onus of change and improvement back on mental health care systems and providers by exploring the relationships between providers' transgender-related knowledge, workplace resources for transgender clients, implicit and explicit transphobic biases, as well as treatment decisions in working with transgender clients. Despite non-significant results on the implicit measure of bias and its relationship to other key variables in the study, the remaining findings suggest that there may be a connection between transgender-related knowledge, explicit transphobia, and treatment decisions. These results can be used to inform targeted and effective interventions to enhance mental health providers' knowledge

relevant to transgender and gender nonconforming individuals, ultimately improving care

delivery and reducing discrimination in mental health care settings for gender minority

consumers.

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Table 1

Demographics and Background Data of the Sample

Gender*	n	%
Ciswoman	56	70.0%
Cisman	21	26.3%
Other gender identity	3	3.8%
Sexual Orientation		
Lesbian/Gay	8	10.0%
Bisexual	7	8.8%
Heterosexual	59	73.8%
Other sexual orientation	6	5.0%
Race		
Black	2	2.4%
Asian/Pacific Islander	3	3.6%
Hispanic	2	2.4%
White	75	89.3%
Native American/Alaskan Native	1	1.2%
Middle Eastern	1	1.2%
Provider type		
Clinical psychologist	24	30.4%
Counseling psychologist	11	13.9%
Psychiatrist	8	10.1%
Social worker	24	30.4%
Other provider type	12	15.2%
In training		
Yes	32	40.5%
No	47	59.5%
Work setting		
Community mental health center	13	16.3%
Outpatient mental health clinic	8	6.6%
Inpatient psychiatric unit	5	4.1%
Substance use facility	6	7.5%
Hospital or medical clinic	4	5.0%
Private practice	7	8.8%
VA center	3	3.8%
University counseling center	4	5.0%
Forensic setting	1	1.3%
Schools	1	1.3%
Residential/group home	7	8.8%
Department/school clinic	6	7.5%
Other setting	15	18.8%

	M	*SD*
Age	36.4	11.8
Years in practice	9.9	9.5
No. of LGBQ acquaintances	3.0	6.2
No. of transgender acquaintances	3.2	9.6
No. of LGBQ coworkers	3.0	2.8
No. of transgender coworkers	.2	.5
No. of LGBQ clients	11.8	14.8
No. of transgender clients	2.4	6.4

*Gender categories represented in this table are condensed; gender in this sample was measured via the two-step method in which sex assigned at birth (female, male, intersex, other) and gender identity (man, woman, other) are asked separately.

Table 2

Providers' Attitudes, Knowledge, and Resources

Attitudes	M	SD
Total explicit bias	6.4	.6
Total implicit bias	.4	2.4
Knowledge		
Know WPATH standards of care	3.5	1.2
Received LGBTQ training	2.3	1.3
Received focused transgender training	3.1	1.5
Workplace offered LGBT training	2.8	1.4
Workplace offered transgender training	3.6	1.3
Know hormone replacement therapy options and effects	3.2	1.2
Know puberty blocker options and effects	3.6	1.2
Know surgical options	3.1	1.3
Know mental health risks	2.5	1.1
Personally sought out info. on transgender issues	2.6	1.3
Confident in working with transgender clients	2.7	1.1
Total knowledge score	3.0	.9
	Yes (*n, %*)	No/Unsure (*n, %*)
Workplace Resources		
Gender neutral bathrooms	36, 42.9%	48, 57.1%
Inpatient accommodations	10, 11.9%	40, 57.6%
Transgender inclusive signage	16, 19.0%	68, 80.9%
Non-discrimination policies	47, 56.6%	36, 43.3%
LGBT-specific therapy/groups	30, 36.1%	42, 50.6%
Transgender-specific therapy/groups	13, 15.5%	60, 71.4%
Information on LGBT resources	58, 69.9%	25, 30.1%
Information on transgender resources	46, 54.8%	38, 45.2%
Medical referral information	25, 29.8%	59, 70.3%

Note: Implicit bias score reflects average reaction time differences; explicit bias score are measured on a scale from one ("strongly agree") to seven ("strongly disagree); knowledge scores reflect a; knowledge scores are measured on a scale from one ("strongly agree") to five ("strongly disagree")

Table 3

Key Variables by Provider Type

	Clinical psychologists (*M, SD*)	Counseling psychologists (*M, SD*)	Psychiatrists (*M, SD*)	Social workers (*M, SD*)	Other (*M, SD*)
Explicit bias	6.366, .649	6.812, .145	5.653, .562*	6.683, .400	6.435, .584
Implicit bias	.888, 3.881	3.214, .683	.499, 2.118	-.214, 1.041	.335, .555
Knowledge score	3.210. .682	2,702, 1.070	3.613, 1.161	2.087, .947*	3.075, .798
Total no/uncertain on resource checklist	5.290, 2.312	3.640, 2.292	6.000, 2.204	4.170, 2.514	4.500, 2.316
Treatment decisions mean difference	.597, .329	1.379, .688*	.771, .333	.771, .434	.472, .340

$*p < .05$

Appendix A

Demographic and Background Data

1. What is your age? _____

2. What is your gender?

    a. Woman

    b. Man

    c. Additional gender not listed above: _____

3. What was your assigned sex at birth?

    a. Female

    b. Male

    c. Intersex

4. What group(s) do you belong to? (Please select all that apply.)

    a. Black/African American

    b. Hispanic/Latina/Chicana

    c. Asian or Pacific Islander

    d. White/European American/Caucasian

    e. Native American/Alaskan Native

    f. Middle Eastern

    g. Multi-racial

    h. Other: _____

5. What is your sexual orientation?

    a. Straight

    b. Lesbian or Gay

    c. Bisexual

    d. Additional orientation not listed above: _____

6. In which state do you work? _____

7. In which county (**not** count**ry**) do you work? _____

8. What type of mental health provider are you?

    a. Clinical psychologist

    b. Counselor

    c. Psychiatrist

    d. Social worker

    e. Psychiatric nurse

    f. (Other): _____

9. Are you currently in training?

    a. Yes

    b. No

10. (If no) How many years have you been in practice? _____

11. What is your terminal degree (either received or currently training for)?

    a. PhD/PsyD

    b. MD

    c. MA/MSc

    d. BA/BSc

    e. Other: _____

12. What is your degree in (for example: Clinical Psychology, Social Work, Counseling

    Psychology)? _____

13. What setting do you work in? Please select all that apply.

    a. Community mental health center

    b. Outpatient mental health clinic

    c. Inpatient psychiatric unit

    d. Substance use facility

e. Hospital or medical school

f. Private practice

g. Other: _____

14. About what percentage of your clients identify as:

   a. Black/African American: _____

   b. Hispanic/Latina/Chicana: _____

   c. Asian or Pacific Islander: _____

   d. White/European American/Caucasian: _____

   e. Native American/American Indian: _____

   f. Middle Eastern: _____

   g. Multi-racial: _____

   h. Other: _____

15. About what percentage of your clients identify as:

   a. Low socioeconomic status: _____

   b. Middle class: _____

   c. High socioeconomic status: _____

16. About how many lesbian, gay, bisexual, or queer clients have you worked with? _____

   a. About what percentage of your clients identify as lesbian, gay, bisexual or queer? _____

17. About how many transgender clients have you worked with? _____

   a. About what percentage of your clients identify as transgender? _____

18. How many lesbian, gay, bisexual, or queer friends or family members do you have? _____

19. How many transgender friends or family members do you have? _____

20. How many lesbian, gay, bisexual, or queer coworkers do you have? _____

21. How many transgender coworkers do you have? _____

Appendix B

Knowledge of Gender Minorities

1. Based on what you know, how would you define the term "transgender"?					
2. Based on what you know, how would you define the term "cisgender"?					
3. Based on what you know, how would you define the term "genderqueer"?					
4. Based on what you know, how would you define the term "transman"?					
5. Based on what you know, how would you define the term "transwoman"?					
6. What would you do if you were meeting with a client and could not figure out the client's gender?					
7. Are you familiar with the World Professional Association for Transgender Health's (WPATH) standards of care for transgender, transsexual, and gender nonconforming people?					
8. If needed, would you have someone to consult with regarding treatment of a transgender client?					
9. How many letters of support have you written for a transgender individual's transition?					
10. Have you ever taken part in a celebration for a transgender individual's changed name, top surgery, or other transition milestone? Would you?					
11. I have received formal training on lesbian, gay, bisexual, and transgender issues.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
12. I have received formal training solely focused on transgender issues.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
13. My workplace has offered training on lesbian, gay, bisexual, and transgender	Strongly	Agree	Uncertain	Disagree	Strongly

issues.	Agree				Disagree
14. My workplace has offered training solely focused on transgender issues.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
15. I know about the administration, effects, potential side effects, and cost of hormone replacement therapy.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
16. I know about administration, effects, potential side effects, and cost of puberty blockers for adolescents.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
17. I know about surgical options for gender transition.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
18. I know about mental health risks and needs that are unique to transgender individuals.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
19. I have sought to educate myself on transgender issues.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
20. I would like more information regarding transgender issues.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
21. I feel confident in my ability to work with transgender clients.	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
22. Do you have any fears or concerns about working with transgender clients? If so, what are they?					

Appendix C

Genderism and Transphobia Scale (GTS)

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
1	2	3	4	5	6	7
Write the number that best indicates how you feel							

1. _____ I have beat up men who act like sissies

2. _____ I have behaved violently toward a woman because she was too masculine

3. _____ If I found out that my best friend was changing their sex, I would freak out

4. _____ God made two sexes and two sexes only

5. _____ If a friend wanted to have his penis removed in order to become a woman, I would openly support him

6. _____ I have teased a man because of his feminine appearance or behavior

7. _____ Men who cross-dress for sexual pleasure disgust me

8. _____ Children should be encouraged to explore their masculinity and femininity

9. _____ If I saw a man on the street that I thought was really a woman I would ask him if he was a man or a woman

10. _____ Men who act like women should be ashamed of themselves

11. _____ Men who shave their legs are weird

12. _____ I cannot understand why a woman would act masculine

13. _____ I have teased a woman because of her masculine appearance or behavior

14. _____ Children should play with toys appropriate to their own sex

15. _____ Women who see themselves as men are abnormal

16. _____ I would avoid talking to a woman if I knew she had a surgically created penis and testicles

17. _____ A man who dresses as a woman is a pervert

18. _____ If I found out that my lover was the other sex, I would get violent

19. _____ Feminine boys should be cured of their problems

20. _____ I have behaved violently toward a man because he was too feminine

21. _____ Passive men are weak

22. _____ If a man wearing makeup and a dress, who also spoke in a high voice, approached my child, I would use physical force to stop him

23. _____ Individuals should be allowed to express their gender freely

24. _____ Sex change operations are morally wrong

25. _____ Feminine men make me feel uncomfortable

26. _____ I would go to a bar that was frequented by females who used to be males

27. _____ People are either men or women

28. _____ My friends and I have often joked about men who dress like women

29. _____ Masculine women make me feel uncomfortable

30. _____ It is morally wrong for a woman to present herself as a man in public

31. _____ It is all right to make fun of people who cross-dress

32. _____ If I encountered a male who wore high-heeled shoes, stockings, and makeup, I would consider beating him up

Appendix D

Affective Priming Task Item Examples: Transgender/Cisgender Implicit Attitudes

Task Execution:

Each "prime" will be shown for 200ms. Then, a 100ms interval of blank screen will be displayed before the "target" image. This produces an ideal stimulus onset asynchrony (SOA) for semantic priming (Klauer, 1997). The target image will then be shown and participants will be asked to rank how positive the image is on a scale from 1 to 3.

Trials iii -10: Neutral images

Directions:
- You will be shown one pairs of images you must memorize (A), and then shown an image you must rank (B).
- Memorize the **first pair** of images (A). These depict the **same** object.
- Then, rank how positive or negative the **second** image (B) is on a scale from 1 to 3 using the keys on your keyboard, where:

1	2	3
Negative	Neutral	Positive

- Respond as fast as possible without making errors.

Trail iii

A:

B:

1 2 3
Negative Neutral Positive

Trial ii

A:

B:

1 2 3
Negative Neutral Positive

Trial iii

A:

B:

1	2	3
Negative	Neutral	Positive

Trials 11 - 30: Cisgender and transgender images

Directions:

- You will be shown one pairs of images you must memorize (A), and then shown an image you must rank (B).
- Memorize the **first pair** of images (A). These depict the **same** person at different points in time.
- Then, rank how positive or negative the **second** image (B) is on a scale from 1 to 3 using the keys on your keyboard, where:

	1	2	3
	Negative	Neutral	Positive

- Respond as fast as possible without making errors.

Trail 11

A:

B:

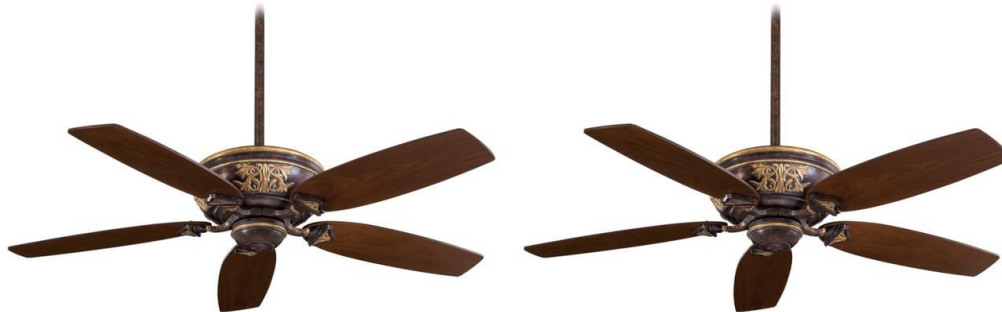| 1	2	3
Negative	Neutral	Positive

Trial 12

A:

B:

1	2	3
Negative	Neutral	Positive

Trial 13

A:

B:

1 2 3
Negative Neutral Positive

Trial 14

B:

1 2 3
Negative Neutral Positive

Trial 15

A:

B:

| 1 | 2 | 3 |
| Negative | Neutral | Positive |

Trial 16

A:

B:

1   2   3
Negative   Neutral   Positive

Appendix E

Workplace Checklist for Transgender Resources and Infrastructure

Directions: Please check off whether your workplace has the following:

	Yes	Uncertain	No	
1. Gender neutral bathrooms	Yes	Uncertain	No	
2. Inpatient accommodations for transgender clients	Yes	Uncertain	No	N/A
3. Transgender inclusive signage/posters	Yes	Uncertain	No	
4. Non-discrimination policies for gender expression and identity	Yes	Uncertain	No	
5. LGBT therapy or support groups	Yes	Uncertain	No	N/A
6. Transgender-specific therapy or support groups	Yes	Uncertain	No	N/A
7. Information on local LGBT resources	Yes	Uncertain	No	
8. Information on local transgender resources	Yes	Uncertain	No	
9. Referral information for medical providers specializing in transgender health care	Yes	Uncertain	No	
10. How does the paperwork in your office ask about clients' gender?				
11. Other resources for transgender clients:				

Appendix F

Transgender/Cisgender Vignettes

Directions: For each scenario, rate how much you agree or disagree with the providers' actions.

Then explain your rating.

1. A counselor is working with a male client who recently became homeless and is now staying at a shelter. The client has requested to begin working on PTSD due to past sexual assault. However, the therapist insists on avoiding trauma work because of the client's current instability. To what extent do you agree with the counselor's actions?						
Strongly Agree	Agree	Somewhat agree	Uncertain	Somewhat disagree	Disagree	Strongly Disagree
Explain:						

2. A social worker had been working with a client for three years when the client realized he was transgender. The social worker decided to shift his case to another social worker who specializes in lesbian, gay, bisexual, and transgender issues— despite the client's reluctance to change providers. To what extent do you agree with the social worker's decision?						
Strongly Agree	Agree	Somewhat agree	Uncertain	Somewhat disagree	Disagree	Strongly Disagree
Explain:						

3. A therapist is working with a middle aged client with bipolar disorder who recently decided to quit her job and go back to school. The counselor suggested that the client should not change her career path until more progress has been made in reaching therapeutic goals. To what extent do you agree with the therapist's suggestion?						
Strongly Agree	Agree	Somewhat agree	Uncertain	Somewhat disagree	Disagree	Strongly Disagree
Explain:						

4. A counselor is working with a transgender client who has just begun the gender transition process from female to male. The client has requested to begin working on PTSD due to past sexual assault. However, the therapist insists on avoiding trauma work because of the client's current instability. To what extent do you agree with the counselor's actions?						
Strongly Agree	Agree	Somewhat agree	Uncertain	Somewhat disagree	Disagree	Strongly Disagree
Explain:						

5. A social worker had been working with a client for three years when the client realized he was bisexual. The social worker decided to shift his case to another social worker who specialized in lesbian, gay, bisexual, and transgender issues— despite the client's reluctance to change providers. To what extent do you agree with the social worker's decision?						
Strongly Agree	Agree	Somewhat agree	Uncertain	Somewhat disagree	Disagree	Strongly Disagree
Explain:						

6. A therapist is working with client with bipolar disorder who recently came out as a transgender man. The counselor suggested that the client should not begin the gender transition process until more progress has been made in reaching therapeutic goals. To what extent do you agree with the therapist's suggestion?						
Strongly Agree	Agree	Somewhat agree	Uncertain	Somewhat disagree	Disagree	Strongly Disagree
Explain:						